

# Introduction to the Summary of Benefits for Valley Advantage Select January 1, 2007 - December 31, 2007 Counties: Hidalgo, Cameron, Willacy

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Thank you for your interest in Valley Advantage Select. Our plan is offered by Valley Baptist Health Plans, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. Please call Valley Advantage Select to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you about some of the features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Valley Advantage Select and ask for the "Evidence of Coverage".

## **YOU HAVE CHOICES IN YOUR HEALTH CARE**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Valley Advantage Select. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Valley Advantage Select at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## **HOW CAN I COMPARE MY OPTIONS?**

You can compare Valley Advantage Select and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer additional benefits, which may change from year to year.

## **WHERE IS VALLEY ADVANTAGE SELECT AVAILABLE?**

The service area for this plan includes: Cameron, Hidalgo and Willacy Counties, TX. You must live in one of these places to join the plan.

## **WHO IS ELIGIBLE TO JOIN VALLEY ADVANTAGE SELECT?**

You can join Valley Advantage Select if you are entitled to Medicare Part A and enrolled in Medicare Part B, entitled to Medicaid, and live in the service area.

## **CAN I CHOOSE MY DOCTORS?**

Valley Advantage Select has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at [www.valleybaptisthealthplans.com](http://www.valleybaptisthealthplans.com). Our customer service number is listed at the end of this introduction.

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## **WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Valley Baptist Health Plans nor the Original Medicare Plan will pay for these services.

## **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

Valley Advantage Select does cover both Medicare Part B prescription drugs and Part D prescription drugs.

## **WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

Valley Advantage Select has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at [www.valleybaptisthealthplans.com](http://www.valleybaptisthealthplans.com). Our customer service number is listed at the end of this introduction.

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Valley Advantage Select uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.valleybaptisthealthplans.com](http://www.valleybaptisthealthplans.com).

If you are currently taking a drug that is not on our formulary or subject to additional requirement or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?**

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and cost at the pharmacy will be lower. When you join Valley Advantage Select, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

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As a member of Valley Advantage Select, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for prescription drug.

## **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Valley Advantage Select for more details.

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Please call Valley Baptist Health Plans, Inc. for more information about this plan.  
Visit us at [www.valleybaptisthealthplans.com](http://www.valleybaptisthealthplans.com) or, call us:

Customer Service Hours:  
7 days a week, 8:00 a.m. - 8:00 p.m. Central.

Current and Prospective members should call (800)-829-6440 for questions related to the Medicare Advantage program. (TTY/TDD (800)-562-5259).

Current and Prospective members should call (800)-829-6440 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (800)-562-5259)

For more information about Medicare, please call Medicare at 1-800-MEDICARE  
(1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.  
Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan’s benefits or costs, please contact Valley Baptist Health Plans.

| BENEFIT CATEGORY  | ORIGINAL MEDICARE  | VALLEY ADVANTAGE   |
|---|--|--|
| <b>IMPORTANT INFORMATION</b>  |  |  |
| <p>If you have both Medicare and Medicaid, you may not have Medicare Part A or B co-pays while you are a member of the Special Needs Plan, although you may have Medicare Part D co-pays for Prescription drug coverage. Please contact the plan for details.</p> |  |  |
| <p>1- Premium and Other Important Information</p>   | <p>You pay the 2007 Medicare Part B of \$93.50 each month.</p> | <p>You pay \$ 0 each month for your plan benefits including your Medicare Part D prescription benefits.</p> <p>You also continue to pay the 2007 Medicare Part B of \$93.50 each month.</p> <p>You pay a \$ 0 yearly deductible for the following Medicare-covered plan services:</p> <ul style="list-style-type: none"> <li>-Home Health Care</li> <li>-Doctor Office Visits</li> <li>-Chiropractic Services</li> <li>-Podiatry Services</li> <li>-Outpatient Mental Health Care</li> <li>-Outpatient Substance Abuse Care</li> <li>-Outpatient Services/Surgery</li> </ul> |

- (1) Each year, you pay a total of \$131 deductible.
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
- (4) Lifetime reserve days can only be used once.

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| BENEFIT CATEGORY | ORIGINAL MEDICARE | VALLEY ADVANTAGE   |
|------------------|-------------------|--|
|                  |                   | <ul style="list-style-type: none"> <li>-Ambulance Services</li> <li>-Emergency Care</li> <li>-Urgently Needed Care</li> <li>-Outpatient Rehabilitation Services</li> <li>-Durable Medical Equipment</li> <li>-Prosthetic Services</li> <li>-Diabetes Self-Monitoring Training and Supplies</li> <li>-Diagnostic Tests, X-Rays, and Lab Services</li> <li>-Bone Mass Measurement</li> <li>-Colorectal Screening Exam</li> <li>-Mammograms (Annual Screenings)</li> <li>-Pap Smears and Pelvic Exams</li> <li>-Prostate Cancer Screening Exams</li> <li>-Dental Services</li> <li>-Hearing Services</li> <li>-Vision Services</li> <li>-Physical Exams</li> <li>-Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>-Partial Hospitalization</li> <li>-Other Health Care Professional</li> <li>-Cardiac Rehabilitation Services</li> </ul> |

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| BENEFIT CATEGORY   | ORIGINAL MEDICARE   | VALLEY ADVANTAGE   |
|--|---|--|
|  |   | -Renal Dialysis<br>-Blood<br>-Medicare Part B Rx Drugs   |
| 2- Doctor and Hospital Choice<br><br>(For more information, see Emergency - #15 and Urgently Needed Care - #16.) | You may go to any doctor, specialist or hospital that accepts Medicare. | You must go to network doctors, specialists, and hospitals.<br><br>You need a referral to go to network hospitals and certain doctors, including specialists for certain services.<br><br>A separate doctor office visit copayment may apply for certain services. |

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| BENEFIT CATEGORY  | ORIGINAL MEDICARE   | VALLEY ADVANTAGE  |
|---|---|---|
| <b>SUMMARY OF BENEFITS</b><br><b>INPATIENT CARE</b>   |   |   |
| <p>INPATIENT CARE<br/>                     3- Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p> | <p>You pay for each benefit period (3):<br/>                     an initial deductible of \$992 - Days 61 - 90: \$248 each day - Days 91 - 150: \$496 each lifetime reserve day (4)</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p> | <p>You pay one initial deductible of \$ 0 for services received at a network hospital.</p> <p>You pay:</p> <p>-\$ 0 each day for day(s) 1-60<br/>                     -\$ 0 each day for day(s) 61-90 for a Medicare-covered stay at a network hospital.</p> <p>You are covered for 60 life time reserve days.<br/>                     You pay:<br/>                     -\$ 0 each day for lifetime reserve day(s) 1-60</p> <p>You are covered for 90-days each benefit period.</p> |

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| BENEFIT CATEGORY                | ORIGINAL MEDICARE  | VALLEY ADVANTAGE   |
|---------------------------------|--|--|
|                                 |  | Except in an emergency, you must get authorization from Valley Baptist Health Plans.   |
| 4- Inpatient Mental Health Care | You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190-days in a Psychiatric Hospital in a lifetime. | <p>You pay one initial deductible of \$ 0 for services received at a network hospital.</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>-\$ 0 each day for day(s) 1-60</li> <li>-\$ 0 each day for day(s) 61-90</li> </ul> <p>for a Medicare-covered stay at a network hospital.</p> <p>You are covered for 60 life time reserve days.</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>-\$ 0 each day for lifetime reserve day(s) 1-60</li> </ul> <p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in emergency, you must get authorization from Valley Baptist Health Plans.</p> |

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| <p>5- Skilled Nursing Facility Care</p> <p>(in a Medicare-certified skilled nursing facility)</p>  | <p>You pay for each benefit period (3), following at least a 3-day covered hospital stay: - Day 1 - 20: \$0 for each day - Days 21 - 100: \$124 for each day.</p> <p>There is a limit of 100 day for each benefit period. (3)</p> | <p>You pay:</p> <p>-\$ 0 each day for day(s) 1-20<br/>-\$ 0 each day for day(s) 21-100 for a Medicare-covered stay at a Skilled Nursing Facility.</p> <p>A 3-day prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.</p> |
| <p>6- Home Health Care</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>There is no copayment for all covered home health visits.</p>  | <p>There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.</p>   |
| <p>7- Hospice Care</p>   | <p>You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.</p>   | <p>You must receive care from a Medicare-certified hospice.</p>   |

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| BENEFIT CATEGORY         | ORIGINAL MEDICARE   | VALLEY ADVANTAGE  |
|--------------------------|---|---|
| <b>OUTPATIENT CARE</b>   |   |   |
| 8- Doctor Office Visits  | You pay 20% of Medicare approved amounts. (1)(2)  | <p>You pay \$ 0 of the cost for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$ 0 of the cost for each specialist visit for Medicare-covered services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> <p>See 32 - Physical Exams for more information.</p> |
| 9- Chiropractic Services | <p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> | <p>You pay \$ 0 of the cost for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>   |

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| BENEFIT CATEGORY                    | ORIGINAL MEDICARE  | VALLEY ADVANTAGE  |
|-------------------------------------|--|---|
| 10- Podiatry Services               | <p>You pay 20% of the Medicare-approved amounts. (1)(2)</p> <p>You pay 20% of the Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p> | <p>You pay \$ 0 of the cost for each Medicare-covered visit (medically necessary foot care).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>                     |
| 11- Outpatient Mental Health Care   | <p>You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</p>  | <p>For Medicare-covered Mental Health services, you pay \$0 of the cost for each individual/group therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| 12- Outpatient Substance Abuse Care | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>For Medicare-covered services, you pay \$ 0 of the cost for each individual/group visit.</p> <p>An additional facility charge may be included in the cost for services.</p>                    |

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| BENEFIT CATEGORY   | ORIGINAL MEDICARE  | VALLEY ADVANTAGE   |
|--|--|--|
| 13- Outpatient Services/Surgery                                    | <p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p> | <p>Except in an emergency, your provider must obtain authorization from Valley Baptist Health Plans.</p> <p>You pay \$ 0 of the cost for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$ 0 of the cost for each Medicare-covered visit to an outpatient hospital facility.</p> <p>An additional facility charge may be included in the cost for services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| 14- Ambulance Services<br>(medically necessary ambulance services) | <p>You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</p>  | <p>You pay \$ 0 of the cost for Medicare-covered ambulance services</p> <p>Authorization rules may apply for services. Contact plan for details.</p>   |

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| <p>15- Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>     | <p>You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2)</p> <p>Your pay 20% of doctor charges. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> | <p>You pay \$ 0 of the cost for each Medicare-covered emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>   |
| <p>16- Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>        | <p>You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>  | <p>You pay \$ 0 of the cost for each Medicare-covered urgently needed care visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>                                   |
| <p>17- Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>You pay \$ 0 of the cost for each Medicare-covered Occupational Therapy visit.</p> <p>You pay \$ 0 of the cost for each Medicare-covered Physical Therapy and/or Speech/Language Therapy</p> |

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|  |  | <p>visit.</p> <p>An additional facility charge may be included in the cost for services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| <p><b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b></p>   |  |   |
| <p>18- Durable Medical Equipment<br/>(includes wheelchairs, oxygen, etc.)</p>                          | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>You pay \$ 0 of the cost for each Medicare-covered item.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>                              |
| <p>19- Prosthetic Devices<br/>(including braces, artificial limbs and eyes, etc.)</p>                  | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>You pay \$ 0 of the cost for each Medicare-covered item.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>                              |
| <p>20- Diabetes Self-Monitoring Training and Supplies<br/>(includes coverage for glucose monitors,</p> | <p>You pay 20% of Medicare-approved amounts. (1) (2)</p> | <p>You pay \$ 0 of the cost for each Medicare-covered Diabetes self-monitoring training.</p> <p>You pay \$ 0 of the cost for each Medicare-covered</p>                    |

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| <p>test strips, lancets, screening tests and self-management training.)</p>           |  | <p>Diabetes Supply item.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>  |
| <p>21- Diagnostic Tests, X-Rays, and Lab Services</p>                                 | <p>You Pay 20% of Medicare-approved amounts, except for approved lab service. (1)(2)<br/>There is no copayment for Medicare-approved lab services.</p> | <p>You pay:</p> <ul style="list-style-type: none"> <li>-\$ 0 of the cost for each Medicare-covered clinical/diagnostic lab service.</li> <li>-\$ 0 of the cost for each Medicare-covered radiation therapy service.</li> <li>-\$ 0 of the cost for each Medicare-covered X-ray visit.</li> </ul> <p>An additional facility charge may be included in the cost for services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| <p><b>PREVENTIVE SERVICES</b></p>   |  |  |
| <p>22- Bone Mass Measurements<br/><br/>(for people with Medicare who are at risk)</p> | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>You pay \$ 0 of the cost for each Medicare-covered Bone Mass Measurement.</p> <p>Authorization rules may apply for services. Contact</p>  |

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|  |  | plan for details.  |
| <p>23- Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>                                       | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>  | <p>You pay \$ 0 of the cost for each Medicare covered Colorectal Screening Exams.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>   |
| <p>24- Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine-for people with Medicare who are at risk, Pneumonia vaccine)</p> | <p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</p> | <p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>You pay \$ 0 of the cost for the Hepatitis B vaccine.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| <p>25- Mammography Screening (Annual Screening)</p> <p>(for women with Medicare age 40 and older)</p>                          | <p>You pay 20% of Medicare-approved amounts. (2)</p> <p>No referral necessary for Medicare-covered screenings.</p>   | <p>You pay:</p> <p>-\$ 0 of the cost for each Medicare-covered Screening Mammogram</p> <p>Authorization rules may apply for services. Contact plan for details.</p>  |

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|   |  | No referral necessary for Medicare-covered screenings.   |
| 26- Pap Smears Pelvic Exams<br><br>(for women with Medicare)                        | There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2)<br>You pay 20% of Medicare-approved amounts for pelvic exams. (2) | There is no copayment for:<br><br><ul style="list-style-type: none"> <li>- Medicare-covered Pap Smears and Pelvic Exams</li> <li>- Additional Pap Smears and Pelvic Exams up to 1 Pap Smear and Pelvic Exam every year</li> </ul><br>Authorization rules may apply for services. Contact plan for details. |
| 27- Prostate Cancer Screening Exams<br><br>(for men with Medicare age 50 and older) | There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)                                   | You pay \$ 0 of the cost for each Medicare-covered Prostate Cancer Screening exams.<br><br>Authorization rules may apply for services. Contact plan for details.   |

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| BENEFIT CATEGORY  | ORIGINAL MEDICARE  | VALLEY ADVANTAGE  |
|---|--|---|
| <p>28- Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs covered under Medicare Part D (Prescription Drug Benefit)</p> <p>Deductible</p> | <p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p> | <p>You pay \$ 0 of the cost for Part B-covered drugs.</p> <p>This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <a href="http://www.valleybaptisthealthplans.com">www.valleybaptisthealthplans.com</a>.</p> <p>You pay no yearly deductible.</p> |

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| BENEFIT CATEGORY           | ORIGINAL MEDICARE | VALLEY ADVANTAGE  |
|----------------------------|-------------------|---|
| Initial Coverage           |                   | Depending on your income level, you pay the lesser of \$ 0 to \$ 2.15 or 15% coinsurance for generic drugs (including brand drugs treated as generic) and the lesser of \$ 0 to \$ 5.35 or 15% coinsurance for all other drugs. |
| In-Network Retail Pharmacy |                   | You may receive drugs for the following:<br>-one month (31 day) supply<br>-three month (90 day) supply  |
| Mail Order                 |                   | You may receive drugs for the following:<br>-three month (90 day) supply  |
| Catastrophic Coverage      |                   | Depending on your income level, after your yearly out-of-pocket drug costs reach \$ 3850, you pay the following for your drugs:<br>-\$ 0 for any drugs; or  |

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|---------------------|-------------------|--|
| General Information |                   | <p>- \$ 2.15 for generic drugs (including brand drugs treated as generic) and \$ 5.35 for all other drugs</p> <p>In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits. Contact plan for details.<br/>Your provider must get prior authorization from Valley Baptist Health Plans for certain prescription drugs.</p> <p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.<br/>Please contact plan for details.</p> |

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|--|---|---|
| <b>ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)</b> |   |   |
| 29- Dental Services  | In general, you pay 100% for preventive dental services.  | <p>There is no copayment for the following:</p> <ul style="list-style-type: none"> <li>- oral exams up to 1 visit every year</li> <li>- cleanings up to 1 visit every year</li> <li>- You are covered up to \$200 for preventive dental services every year.</li> </ul> <p>You pay \$0 of the cost for each Medicare-covered dental benefit.</p>                    |
| 30- Hearing Services   | <p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1) (2)</p> | <p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> <li>- Medicare-covered hearing exams (diagnostic hearing exams)</li> <li>- Routine hearing tests up to 1 visit per year</li> <li>- Fittings-evaluations for a hearing aid up to 1 visit every year</li> </ul> <p>There is no copayment for hearing aids up to 1 aid</p> |

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| BENEFIT CATEGORY    | ORIGINAL MEDICARE   | VALLEY ADVANTAGE   |
|---------------------|---|--|
|                     |   | every three years.<br><br>You are covered up to \$300 for hearing aids every year.<br><br>Authorization rules may apply for services. Contact plan for details.  |
| 31- Vision Services | You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)<br><br>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)<br><br>Your pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)<br><br>You pay 100% for routine eye exams | There is no copayment for the following services:<br>- Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye)<br>- routine eye exams up to 1 visit per year<br><br>There is no copayment for the following services:<br>- Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery)<br>- Glasses, limited to 1 pair of glasses every year.<br>- Contacts, limited to 1 pair of contacts every year.<br><br>You are covered up to \$200 for eye wear every year. |

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|-----------------------------|---|---|
|                             | and glasses.  | Authorization rules may apply for services. Contact plan for details.   |
| 32- Physical Exams          | <p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.</p> | <p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay \$ 0 of the cost for Medicare covered services.</p> <p>There is no copayment for routine physical exams.</p> <p>Authorization rules may apply for services. Contact plan for details.</p> |
| Health / Wellness Education | You pay 100%.   | <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletter</li> <li>- Other Wellness Services</li> </ul>   |

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